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DATE NOTICE SENT TO ALL PARTIES: 5/13/16

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
The item in dispute is the prospective medical necessity of a right wrist MRI without contrast.

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION
The reviewer is a Medical Doctor who is board certified in Orthopedic Surgery. The reviewer has been practicing for greater than 10 years.

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

☐ Upheld (Agree)

☒ Overturned (Disagree)

☐ Partially Overturned (Agree in part/Disagree in part)

The reviewer disagrees with the previous adverse determination regarding the prospective medical necessity of a right wrist MRI without contrast.

A copy of the ODG was not provided by the Carrier or URA for this review.

PATIENT CLINICAL HISTORY [SUMMARY]:
The female was injured while carrying heavy cases of X. She felt significant right wrist/hand pain while attempting to stop one or more from falling. Diagnoses have included flexor tenosynovitis. An XX/XX/XX dated wrist MRI evidenced extensor tenosynovitis and degenerative changes. Slight positive ulnar variance was noted on x-rays. Treatment had included medications, splinting, therapy and altered activities. Clinical notes including from XX/XX/XX discussed persistent volar wrist pain, crepitus and slight residual flexion and extension deficits. XX/XX/XX, pain relief post injection was noted. Pain along with volar wrist

tenderness, crepitus and swelling was noted. Denial letters discussed the lack of documented progressively abnormal clinical findings and or support for a repeat MRI. An appeal discussed the unreliability of the 9 month old MRI, persistent pain findings along with reportedly new volar synovitis clinically.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.

The injured party has been extensively and comprehensively treated over the last year. Despite same, there is persistent wrist pain. However, whereas the 9 month old wrist MRI reflected dorsal synovitis, the current findings are now volar. This represents a documented material and plausibly adverse change. The soft tissue findings do warrant an additional diagnostic work-up. Therefore, guideline criteria referenced below have been met, as has medical necessity.

Reference: ODG Wrist Chapter
Indications for imaging -- Magnetic resonance imaging (MRI):
- Acute hand or wrist trauma, suspect acute distal radius fracture, radiographs normal, next procedure if immediate confirmation or exclusion of fracture is required
- Acute hand or wrist trauma, suspect acute scaphoid fracture, radiographs normal, next procedure if immediate confirmation or exclusion of fracture is required
- Acute hand or wrist trauma, suspect gamekeeper injury (thumb MCP ulnar collateral ligament injury)
- Chronic wrist pain, plain films normal, suspect soft tissue tumor
- Chronic wrist pain, plain film normal or equivocal, suspect Kienböck's disease
- Repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ☐ **ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE**
- ☐ **AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES**
- ☐ **DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES**
- ☐ **EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN**
- ☐ **INTERQUAL CRITERIA**
- ☒ **MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- ☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**
- ☐ **MILLIMAN CARE GUIDELINES**
- ☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
- ☐ **PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR**
- ☐ **TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**
- ☐ **TEXAS TACADA GUIDELINES**
- ☐ **TMF SCREENING CRITERIA MANUAL**
- ☐ **PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**
- ☐ **OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**